Request for Alternate Communications

Date:_____
Name:_____

I. Request for Restriction

I hereby request that I receive communications of my protected health information from Kentucky Employees Health Plan (the "Plan"), as follows:

Specifically, I request that the following communications be subject to the above request:
_____

Alternative means of contact: _____

The disclosure of all or part of the information to which this request pertains could endanger me.

II. Other Important Information

I understand that the Plan will agree to all reasonable requests, but may condition this accommodation on, when appropriate, information as to how payment, if any, will be handled; and my specifying above an alternative means of communication.

III. Signature of Member or Member's Representative

_____ _____
Signature of member or member's representative **Date**

(Form MUST be completed before signing.)

Printed name of the member's personal representative:

_____

Relationship to the member, including authority for status as representative:

_____

_____
Signature

_____
Printed

Department of Employee Insurance
501 High Street, 2nd Floor
Frankfort, Kentucky 40601
(502) 564-6534